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Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives

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LONG-TERM CARE INSURANCE

Risks to Consumers Should Be Reduced

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Human Resources Division

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The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

In 1989 hearings before your Subcommittee, we identified significant problems with long-term care insurance policies and with the model standards developed for this insurance by the National Association of Insurance Commissioners (NAIC). Many policies were found to be expensive and restrictive. States were slow to adopt model regulatory standards, and the standards offered little consumer protection in such key areas as inflation protection.

In light of these problems, you asked us to determine (1) to what extent state standards and long-term care insurance policies meet NAIC standards, (2) how adequately the standards and policies address critical consumer protection issues, and (3) whether minimum federal standards are needed. At a hearing before the Subcommittee last April, we provided preliminary results of our work.[1] At that hearing, we and others identified significant problems with long-term care insurance policies and insufficiencies in NAIC's model standards.

Results in Brief

Today's NAIC model standards for long-term care insurance provide greater consumer protection than existed before 1986. However, consumers are still vulnerable to considerable risks for two major reasons. First, although state standards have improved, many states have not adopted key NAIC standards, including some developed between 1986 and 1988. For example, 23 states have not adopted NAIC standards requiring insurers to guarantee policy renewal, and 19 have not adopted the standards disallowing Alzheimer's disease exclusions. The NAIC standards, although not mandatory, suggest the minimum regulatory standards states should adopt. Insurers have adopted NAIC standards more quickly than states have, but most policies we reviewed did not meet more recent NAIC standards, particularly those regarding disclosure and inflation protection.

[1] Long-Term Care Insurance: Risks to Consumers Should Be Reduced (GAO/T-HRD-91-14, Apr. 11, 1991).

Private long-term care insurance policies typically offer indemnity benefits for nursing care. The policies pay a set amount each day for a specific period of time a policyholder receives care. A policy may or may not cover all types of long-term care (generally termed as skilled, intermediate, and custodial care), and policies may define covered long-term care services or facilities differently. Many policies also cover home health care services, which can refer to skilled nursing care provided at home by medical professionals. Home health care services can also refer to assistance with such daily living activities as eating and bathing, which can be provided by people without medical skills.

Traditionally, states have had the primary responsibility for regulating the insurance industry. State insurance agencies are linked through NAIC, which is composed of the heads of the state agencies. In 1986 NAIC established model standards that have evolved rapidly. Although the standards are not mandatory, they suggest the minimum standards states should adopt for regulating long-term care insurance. Today, the standards also provide increased consumer protection while offering insurance companies flexibility to experiment with different products in a competitive, emerging market. (A list of key consumer protection provisions of the NAIC standards is presented in appendix I.)

Because states have the responsibility for setting long-term care insurance standards, they must determine the balance between consumer protection and the insurance industry's need for flexibility. An appropriate balance is difficult to achieve. For example, limitations in long-term care insurance policies can reduce both benefit eligibility and the benefits available. To the extent that such limitations are removed and coverage increased, however, policy prices can increase to levels that are unaffordable for many consumers.

Scope and Methodology

To review state standards for long-term care insurance, we compared each state's applicable laws and regulations with NAIC standards. To determine the status of policies, we reviewed 44 policies for sale by 27 insurers in 8 states (Alabama, Arizona, California, Florida, Missouri, New Jersey, Pennsylvania, and Washington). The policies were randomly selected from insurers whose policies had been approved for sale by the states' insurance regulatory agencies (see app. II).

We consulted officials at NAIC, the Department of Health and Human Services, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association. We also consulted major consumer

Policies Improved but Do Not Meet Recent NAIC Standards

Insurers have adopted NAIC standards more quickly than states have. With the exception of standards for outlines of coverage, most of the 44 policies we reviewed met the key NAIC standards developed in 1988 or earlier. The policies often did not meet more recent NAIC standards, however, regarding disclosure, inflation protection, and home health care.

Disclosure

Disclosure standards help clarify or simplify policies and help protect consumers from unfair or deceptive marketing practices. For instance, NAIC standards require that insurers provide consumers with outlines of coverage, using a specific format and content, that summarize policy provisions. Despite this specificity, 41 of the 44 outlines of coverage we reviewed did not meet NAIC standards. Other disclosure information protects policyholders from post-claims underwriting. For example, NAIC standards require that policy applications include a statement cautioning policyholders against incorrect or untrue answers. The NAIC statement also cautions that invalid information gives an insurer the right to deny benefits or cancel the policy. However, 28 of the 44 applications we reviewed did not contain this statement.

Additional NAIC standards help protect consumers from unfair or deceptive marketing practices. For example, NAIC standards require specific information from policy applicants to help determine whether insurance agents are selling unnecessary insurance or unfairly targeting individuals. None of the applications we reviewed met all NAIC standards. For example, 20 did not ask whether the applicants were already covered by Medicaid, and 42 did not ask whether they had other long-term care insurance in the past 12 months and who sold it to them.

Disclosure standards cover important information insurers need to determine whether an applicant should purchase long-term care insurance. We found several cases of insurers with aggressive sales agents selling policies to consumers who did not need them. In one case, the state of California brought suit against an insurance agency whose agents sold to over 100 older consumers policies that duplicated covered benefits or were otherwise unnecessary. For example, over 3-1/2 years, the agents sold an elderly man 16 different health policies, about half of which provided nursing home coverage. These practices might have been avoided if the insurer had met NAIC disclosure requirements and used the information to monitor its agents.

nursing home care requirement, and five contained the physician certification requirement.

NAIC Standards Silent on Key Policy Features

Consumers face many difficulties in assessing long-term care policies, even when policies meet current NAIC standards. Some of these difficulties arise because policies vary so widely in how they define covered services and eligible facilities, and how they determine eligibility for benefits. Others arise because provisions that can restrict access to benefits are vague or so subtle and complex that their implications for coverage and eligibility limitations are not obvious. Policyholders may not discover these restrictions until they file for benefits. Despite the potential for disputes between policyholders and insurers about benefit eligibility, recourse is limited—most long-term care policies do not provide a grievance process. NAIC standards are silent on these issues.

Services and Facilities

Consumers confront an array of policies made bewildering by the absence of uniform terms and definitions. This absence of uniformity makes it difficult or impossible to compare policies and to judge which provisions could reduce the likelihood a policyholder would receive benefits. For example, in our sample of policies, some used terms relative to services (such as "custodial care" and "plan of care") that were not used in others. Further, common terms for services and facilities (such as "nursing home") were often modified by definitions that differed considerably and could in effect preclude covering the intended services or eliminate the policyholder's area nursing homes from the pool of eligible facilities. These consequences likely would not be foreseen except by those especially knowledgeable about provider requirements and the delivery of long-term care services in a given state.

In short, the limitations of certain policy provisions may be difficult to identify. Of the 44 policies we reviewed, 23 contained restrictions on what was meant by skilled, intermediate, and custodial care, and 37 contained restrictions on what was meant by eligible facilities. These restrictions were not obvious. For example:

- 10 policies did not provide benefits generally included in skilled or intermediate care. For instance, several policies excluded physical therapy from their coverage of skilled services, although the service is included in Medicare coverage of skilled care.
- 12 policies required that custodial care be provided in a skilled or intermediate care facility. Custodial beds in these facilities, however, may be

addition to problems with the definition, medical necessity is not a relevant eligibility criterion for policyholders who do not need medical services. Some policyholders may need only custodial or home health care due to physical or cognitive impairments.

A policyholder may need medical care as part of custodial or home health care services, but some policies do not provide benefits beyond those already provided by Medicare. To be able to recognize and understand this limitation, consumers must be knowledgeable about Medicare's coverage of services and how a policy's coverage compares. For example, Medicare pays only for medically necessary care—intermittent skilled nursing care, physical therapy, or speech therapy. This care is provided by professional nurses or therapists, as well as by home health aides who help physically impaired patients. But of the 13 policies we reviewed that base home health care on medical necessity, 9 did not offer any more coverage than that provided by Medicare, and 4 offered even less because they did not cover home health aid services. Moreover, 5 of the 13 policies specifically indicated that they would not pay for any benefits covered by Medicare.

Insurers are beginning to use eligibility criteria other than medical necessity, such as activities of daily living (ADLs). ADLs include bathing, transferring from a bed or a chair, dressing, toileting, and eating. In using these criteria, insurers determine impairment by evaluating a policyholder's physical ability to perform ADLs. Although ADLs are promising criteria for determining eligibility, some of the policies we reviewed presented significant problems. Of the 27 policies that used ADLs, 17 did not specify or describe the ADLs that the insurer would use to determine benefit eligibility. For example, one policy required that policyholders be physically unable to perform the activities of daily living, but did not specify what these activities were. Without this information, the circumstances under which the insurer would have provided benefits were unclear.

Another eligibility criterion involves how insurers assess a policyholder's competence to perform ADLs. Some policies consider individuals to be impaired only if they require active human assistance to perform ADLs; the active human assistance requirement can reduce the number of elderly qualifying for benefits by 40 percent.[5] A more lenient criterion bases a determination of impairment on the policyholder's need for

[5]J. Wiener and K. Harris. High Quality Private Long-Term Care Insurance: Can We Get There From Here? (Washington, D.C.: The Brookings Institution, May 1990), p. 11.

Provisions stipulating an insurer's time limit to respond give policyholders a safeguard against inordinate delays. In one state we visited, a policyholder who requested reconsideration of a denied claim did not receive a written reply from the insurer for 6 months.

NAIC Standards Do Not Protect Consumers From Pricing or Marketing Risks

Consumers face considerable pricing and marketing risks in purchasing long-term care insurance. Policy prices vary substantially for policies with similar coverage, key assumptions used by insurers to support prices may not be valid, and unpredictable premium increases may make it difficult for policyholders to retain their policies. Policyholders who allow their policies to lapse, however, almost always lose the entire investment component of their premiums. NAIC standards do not address this issue. Consumers are also vulnerable to risks incurred by certain marketing practices, such as limited upgrading options for existing coverage and high first-year sales commissions that provide incentives for agent abuse. NAIC standards do not address the problem of upgrading policies and only suggest that states that have identified marketing abuses consider adopting NAIC standards relative to sales commissions.

Differences in Premiums for Similar Policies

Premiums charged for similar policies differ substantially, and there is little consensus among actuaries on the definition of a reasonable price. As a result, we could not rely on price as a good measure of value. For example, we compared the annual premiums for 14 policies in our sample. The premiums were based on coverage for a 75-year-old who obtains a policy that provides 3 years of nursing home care, begins paying $80 per day after the first 90 or 100 days of nursing home care confinement, and provides no inflation protection. We found that annual premiums for four policies that offered only nursing home care ranged from about $1,200 to $1,600 (a difference of 33 percent). Premiums for six policies offering nursing care and home health care ranged from about $1,200 to $3,000 (a difference of 150 percent). Premiums for six other policies that offered nursing home care as well as home health and adult day care ranged from about $1,400 to $2,700 (a difference of 93 percent). To the consumer, policies in each of these groups would have appeared similar because they offered the same basic benefits and dollar coverage. Moreover, the differences in the premiums across these three groups illustrate that consumers could buy policies that provided a full range of benefits (nursing home care, home health care, and adult day care) at the same price as policies that provided only nursing home care.

Lack of Nonforfeiture Benefits

Consumer vulnerability to financial loss is compounded by the fact that policyholders who do not retain their policies almost always forfeit the investment component of their premiums.[7] On average, insurers we reviewed expected that 60 percent or more of their original policyholders would allow their policies to lapse within 10 years; one insurer expected an 89-percent lapse rate.[8] In all but two policies we reviewed, policyholders who allow their policies to lapse would lose the entire investment component of their premiums. NAIC standards do not require insurers to provide nonforfeiture benefits. Such benefits provide a return of a portion of the reserves resulting from policyholders' premium payments.

Nonforfeiture benefits would significantly enhance the value of policies. For example, on the basis of our review of 44 policies, a consumer who purchased a policy at the age of 75 and allowed it to lapse at the age of 85 would, on average, lose nearly $20,000 in premiums. For the two policies in our sample that offered nonforfeiture benefits, the policyholder would receive back about $12,000 to $14,000 of the $20,000. The policyholder would receive nothing back on any of the other 42 policies.

Limitations on Policy Upgrading

Neither NAIC standards nor the state standards from our sample addressed the issue of upgrading policies. This can be particularly troublesome for the more than 1.1 million consumers who purchased earlier-generation policies that contain overly restrictive provisions now prohibited by NAIC, such as a prior hospitalization requirement. Today, many policyholders who bought such policies and who want to upgrade them to current standards may do so only with significantly higher premiums, if at all. These policyholders must meet the same requirements and terms as new purchasers. That is, they must meet the insurer's criteria for medical underwriting and preexisting conditions, as well as pay the premium for their particular age group. The premium generally more than doubles for the 10-year difference between ages 65 to 75. None of the policies we reviewed offered the option of upgrading the policy under more favorable conditions.

[7]Most long-term care insurance policies, similar to whole-life policies, have fixed annual premiums. Insurers price such a policy so that it accrues substantial investment reserves in the early years to cover the increased risk for the insurers in the later years. Unlike whole-life policies, however, long-term care policies generally do not give policyholders who allow their policies to lapse any return of the investment reserves.

[8]This analysis included 20 policies for which we had lapse rate data and that excluded mortality as a basis for lapsing.

In addition, NAIC standards do not sufficiently address several significant issues. For example, the absence of uniform terms, definitions, and eligibility criteria makes it difficult or impossible to compare policies. It is especially difficult for consumers to understand under what circumstances benefits will be provided and how certain provisions can limit eligibility. Consumers also face considerable pricing risks, such as unpredictable premium increases, that may force many policyholders to lapse policies and lose their investment component in premiums. Finally, in the absence of standards, consumers are limited in their options to upgrade policies and are vulnerable to sales abuses created by high first-year commissions.

To address these issues, we believe that additional standards are necessary. These standards should

- promote uniformity of terms and definitions for long-term care services, facilities, and eligibility criteria;
- establish guidelines that address the relevance of eligibility criteria for different types of impairments;
- establish formal grievance procedures;
- establish requirements for nonforfeiture benefits;
- establish options for upgrading coverage; and
- establish a sales-commission structure for long-term care insurance, as was done for Medigap insurance, that reduces incentives for marketing abuses.

These standards would likely increase premiums. We believe, however, that they would significantly improve consumer protection in a rapidly evolving, complex market. Further, adding these standards to existing NAIC standards is consistent with an approach of incrementally strengthening standards while giving insurers the flexibility to experiment with and improve their products. As of November 1991, NAIC's Long-Term Care Insurance Task Force was considering several of these standards.

New standards alone would not ensure adequate consumer protection. Despite substantial progress in recent years, many states have not adopted key NAIC standards, and when they will do so is uncertain. Therefore, if states do not adopt the NAIC standards, the Congress may wish to consider enacting legislation that sets minimum federal standards for long-term care insurance. Such legislation could include the current NAIC standards and the additional standards suggested in this report.

1989 Changes to Model Act and Regulation

Require 30-day free look; delete 10-day option.

Set minimum standards for home health care benefits.

Require that inflation protection be offered as an option.

Require disclosure information to protect against post-claims underwriting.

1990 Changes to Model Act and Regulation

Require delivery of a Shopper's Guide that provides an overview of long-term care insurance policies, including types of coverage, benefits, and costs.

Eliminate prior hospitalization as a requirement.

Require inflation protection to compound benefits annually by at least 5 percent.

Require insurers to annually report to states the number of policy lapses and replacements and to track agent sales.

Require disclosure information on policy applications to guard against the sale of duplicative and unnecessary insurance.

Require several controls on agents, such as testing, licensure, and making reasonable efforts to determine appropriateness of sales.

Require insurers to establish marketing procedures to assure that any comparison of policies by their agents is fair and accurate.

Limit the agent commission structure for the first year and renewal years (optional).

Prohibit high-pressure tactics and other abusive marketing practices.

State Enactment of Key NAIC Provisions

NAIC provision[a,b]	Consumer protection: Equal to or more than model	Consumer protection: Less than model	No provision
Requires guaranteed renewability	28	2	21
Prohibits prior hospitalization	32	8	11
Prohibits Alzheimer's disease exclusions	32	2	17
Standards for home health care	11	1	39
Meets inflation protection standard[c]	11	6[d]	34
Application disclosure requirements to prevent post-claims underwriting	11	0	40
Prohibits stepdown provisions[e]	28	1	22
Cannot limit to skilled care or give significantly more coverage for skilled care than other care	35	4	12
Has preexisting condition limits[f]	23	23	5
Requires outline of coverage	21	25	5
Standard format and content for outline of coverage	21	4	26
Requires uniform 30-day free look[g]	29	12	10
Standards for loss ratios	26	6	19

[a]Compliance with NAIC standards was based on states' long-term care insurance acts and regulations as of January 1991. Data were provided by NAIC.

[b]Includes the District of Columbia; thus, states add to 51.

[c]We compared states to a standard requiring that inflation protection be compounded annually.

[d]One state sets minimum caps on inflation protection but does not require compounding.

[e]Stepdown provisions require policyholders to obtain higher levels of care before they become eligible for lower levels. This would, for example, require that skilled nursing care be received before custodial care would be covered.

[f]Preexisting condition is one for which medical advice or treatment was recommended by or received from a health care provider within 6 months before the effective date of coverage. A policy cannot deny coverage of such a condition after 6 months of effective coverage.

[g]We evaluated standards for individual policies only; ranking would differ for some states if group policy standards were included.

must estimate how many claims they expect to receive in the future with little actual experience on which to base their estimates. As a substitute, insurers have based their estimates on data from published studies, such as national nursing home surveys, that involve populations that are insured for long-term care. These estimates are "best guesses," however, because insured populations may have a higher use of long-term care services than populations that are not insured for long-term care. Estimates will remain best guesses for some time. In the absence of actual experience data, actuaries have not reached a consensus on what reasonable estimates are for the use of long-term care services. Moreover, most policyholders will not need such services for years to come.

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Insurer Assumptions in Pricing Policies

Long-term care insurance policies that offer similar benefits can differ widely in price because of differences in insurers' pricing assumptions. But there is a great deal of uncertainty in the market about the validity of some of these assumptions in the absence of experience (use of services) data. Because the market is relatively new, it is difficult for insurers to estimate the number of policyholders who will keep their policies and eventually use covered services.

Insurers base policy prices on at least four key actuarial assumptions: (1) expenses that the insurer expects to incur, such as commissions, tax on premiums, and processing of claims; (2) the interest rate, such as the interest the insurer expects to receive on reserves; (3) the lapse rate, the percentage of policyholders the insurer expects to stop paying premiums on policies before they receive benefits; and (4) the rate at which the insurer expects policyholders to use covered services. Our review of actuarial memoranda, available for 32 of the 44 policies in our sample, illustrated how sensitive pricing is to these assumptions.

We determined the impact of three of the key pricing assumptions on a standard policy's gross premiums. The premiums were based on coverage for a 75-year-old who obtains a policy that covers three levels of nursing home care (skilled, intermediate, and custodial) and home health care; provides coverage for 3 years; and pays $80 daily. We found, for example, that:

- Expenses ranged from about 19 to 50 percent of premiums in the 25 policies for which we could determine expenses. With these expectations, annual premiums for a standard policy were priced from $1,527 to $2,474 (a difference of 62 percent).[1]
- Interest rates, ranging from 5 to 9 percent, resulted in annual premiums of $1,796 to $1,902 (a difference of about 6 percent).
- Cumulative lapse rates expected by insurers after 10 years, ranging from 37 to 89 percent, resulted in annual premiums of $1,591 to $1,979 (a difference of about 24 percent).

We were unable to obtain sufficient data from the actuarial memoranda to evaluate the impact of assumptions concerning the use of long-term care services. Such assumptions, however, may be the principal reason for pricing variations among policies on the market.[2] Currently, insurers

[1]Higher interest rates and lapse rates result in the lower premiums, while a higher expense rate will increase premiums.

[2]M. Peavy, "The Price Is Right," p. 28.

Insurance Companies Represented in GAO Review

Aid Association for Lutherans
Amex Life Assurance Company
Bankers United Life Assurance Company
Blue Cross of Washington and Alaska
Certified Life Insurance Company
Combined Insurance Company of America
Consumer Service Casualty Insurance Company
Continental Casualty Company
Federal Home Life Insurance Company
Great Fidelity Life Insurance Company
Great Republic Life Insurance Company
John Hancock Mutual Life Insurance Company
Life and Health of America
Life Investors Insurance Company of America
Mutual of Omaha Insurance Company
Mutual Protective Insurance Company
Northwestern National Life Insurance Company
Old American Insurance Company
Penn Treaty Life Insurance Company
Pennsylvania Life Insurance Company
Physicians Mutual Insurance Company
Pioneer Life Insurance Company of Illinois
The Travelers Insurance Company
Time Insurance Company
Union Bankers Insurance Company
United American Insurance Company
United General Life Insurance Company

Key Consumer Protection Provisions of NAIC Long-Term Care Insurance Model Act and Regulation

1986 and 1987 Model Act Provisions

Prohibit policy cancellation because of age and deteriorating health.

Limit the length of time insurers may exclude coverage for preexisting conditions to 6 months, with no distinction based on age.

Furnish policyholders with an outline of coverage detailing policy benefits, exclusions, and renewal provisions.

Offer consumers a 10- to 30-day "free-look" period within which to return a policy for any reason and receive a complete premium refund.

Prohibit policies that offer coverage for only skilled care.

1987 Model Regulation Provisions

Prohibit exclusions for Alzheimer's disease.

Require individual policies to be guaranteed renewable or noncancellable.

Require individual policies to have an expected loss ratio of at least 60 percent.[1]

Require that benefits continue after policy termination if institutionalization begins while the policy is in force and continues without interruption after termination.

1988 Changes to Model Act and Regulation

Prohibit hospitalization as a condition of eligibility (as an alternative to total prohibition, the amendment suggests requiring those insurers who retain the restriction to also offer coverage without the restriction).

Prohibit receipt of benefits at a higher level of nursing home care as a condition of eligibility for benefits at a lower level of care.

Require a standard format and content for an outline of coverage.

[1]Loss ratio measures the percentage of each premium dollar policyholders can expect to receive back as benefits over the duration of the policy. A loss ratio of 60 percent requires that insurers price policies with the expectation that in the aggregate, 60 percent of premiums collected will be paid out as benefits.

Contents

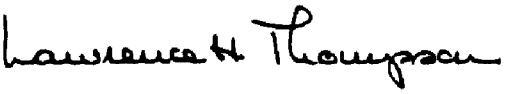
Abbreviations

ADL	activity of daily living
GAO	General Accounting Office
NAIC	National Association of Insurance Commissioners

We are sending copies of this report to the Secretary of Health and Human Services, the President of the National Association of Insurance Commissioners, and other interested parties and will make copies available upon request.

This report was prepared under the direction of Janet Shikles, Director, Health Financing and Policy Issues, who may reached on (202) 275-5451. Other major contributors are listed in appendix V.

Sincerely yours,



Lawrence H. Thompson
Assistant Comptroller General

Incentives for Marketing Abuses

Some insurers in our sample paid high first-year commissions for the sale of their long-term care policies. The size of commissions and the methods of payment are of concern to NAIC because high sales commissions have created incentives for abuses in the sale of other insurance policies to older people. For example, large commissions associated with the initial sale of Medigap policies created undesirable incentives for agents to "churn" (that is, to sell) new policies to their customers.[9] Essentially, agents received large commissions on the initial sale of such policies and small commissions on renewals.

Medigap standards have been revised to reduce incentives to churn policies by limiting the size of the first-year commissions and other compensation that may be paid to a sales agent. In addition, the standards require companies to spread the total compensation over several years. NAIC has adopted the same Medigap standards for long-term care insurance. But NAIC established the standards as an option that states and insurers should consider adopting if they identify marketing abuses. The standards stipulate that insurers should limit first-year commissions to no more than 200 percent of the commissions paid in the second year. In renewal years, insurers should limit commissions at the same rate as those paid in the second year for a reasonable number of years.

Long-term care policies are often more expensive than Medigap policies. As a result, agent commissions can be substantial. For example, of 16 policies for which data were available, only 1 paid first-year commissions that would meet NAIC's optional standards. The other policies paid substantially higher commissions. On average, commissions were about 60 percent of the total value of the first year's premium. For half of the policies, this was at least twice NAIC's recommended rate. With one such policy, a sales agent could earn an initial commission of $2,000 (based on a 70-percent commission rate) for selling the policy to a 75-year-old consumer. These types of commissions provide considerable incentives for agents to sell policies to consumers who do not need them.

Conclusions and Matter for Consideration

NAIC's long-term care insurance standards, which provide a national model for the states, have improved significantly in the past 5 years. Although state standards have also improved, many states have not adopted key NAIC standards, and insurers have not incorporated more recent NAIC standards into their policies.

[9]Medigap refers to private insurance policies designed to fill some of the gaps in Medicare coverage, such as deductibles and copayments.

Policies that offer similar coverage can differ widely in price because of the differences in insurers' pricing assumptions (see app. IV). For example, two policies we reviewed provided similar coverage but differed in price by about 52 percent because one insurer assumed a lower rate for the use of services than the other insurer did. Assessing the validity of the insurers' assumptions is difficult, given the absence of experience data. Most current policyholders will not need long-term care services for many years to come.

Premium Increases

Policyholders who obtain long-term care insurance at the lowest market price cannot be sure that the policy will remain a bargain. Under NAIC standards, insurers can increase premiums on existing policies. Insurers can thus transfer from themselves to aging policyholders a substantial portion of the risk associated with long-term care insurance; that is, insurers who incur more claims than expected can simply increase premiums.

Premium increases can place policyholders at risk of being priced out of the market at the time when they are at greatest risk for needing long-term care services. The risk of future premium increases may be significant, given that some insurers may initially underprice policies because of the extremely competitive market.[6] Low initial prices work to consumers' advantage only if insurers do not raise prices significantly in the future. However, pricing policies in a new market without data on the use of long-term care services will require insurers to make adjustments.

Because the long-term care insurance market is still developing, the extent to which policy prices will increase remains uncertain. However, some recent increases in premiums that we reviewed were significant. For example, in the three states from which we were able to obtain data, we identified 13 insurer requests for price increases, resulting in 12 approvals. Arizona had 11 of the 13 requests for price increases, ranging from 15 to 54 percent. These requests were quite recent. Between 1988 and 1990, the state allowed increases for all 11 policies. In one instance, Arizona allowed a 30-percent increase on three policies issued by one insurance company. The state had previously granted a rate increase for one or more of the three policies.

[6]M. Peavy, "The Price Is Right," Best's Review (Nov. 1989).

"supervision or standby" help or mechanical assistance. Of the 27 policies that used ADL criteria, only 1 used the supervision or standby assistance requirement. The rest used criteria to assess impairment that were not clear-cut: 17 required human assistance but did not specify whether it had to be active, and 9 did not specify the type of assistance required.

In some cases ADLs alone may not be sufficient to assess impairment. For example, nearly all policies specifically claim to cover policyholders with Alzheimer's disease. Many people with Alzheimer's disease, however, do not have serious ADL limitations. These people—who suffer from cognitive impairment and need supervision—require different eligibility criteria. However, absent any measure of cognitive impairment, policyholders with Alzheimer's disease must meet other requirements or be denied coverage. Of 27 policies that contained ADL criteria, only 8 included cognitive impairment as a criterion.

Finally, policies that combined a medical necessity requirement with ADL criteria or measures of cognitive impairment presented special problems. For example, 5 of the 27 policies with ADLs required that a policyholder meet both a medical necessity requirement and ADL criteria to obtain benefits. Under these policies, a policyholder needing only ADL assistance would not receive benefits.

Grievance Process

Despite the prevalence of ambiguous provisions and eligibility requirements, most policies in our sample did not have a formal grievance process. A grievance process allows policyholders to formally contest insurers' decisions about their eligibility. At a minimum, such a process could help to resolve different interpretations of contractual obligations between policyholders and insurers in a forum other than formal legal proceedings. Despite the value of this process, NAIC standards do not address grievance procedures.

Of the 44 policies we reviewed, 10 (representing 5 insurers) offered some type of grievance process. Each of the 10 policies stipulated that the insurer would reconsider claims and review any materials submitted by policyholders to support their claims. Policyholders must submit their reconsideration requests in writing. Seven of the 10 policies also stated that the insurer would respond to the grievance, in writing, within a specific period (30 or 60 days). The remaining policies stated only that the insurer would respond to the grievance promptly.

in short supply. Moreover, policyholders do not have the option of seeking custodial care in facilities that do not provide skilled or intermediate care, even though such facilities may be available.

- 12 policies required a specific number of residents for custodial facilities. This requirement may be more stringent than state regulations. For instance, a policy sold in Arizona required that custodial care facilities maintain at least 25 residents, even though state regulations allowed for fewer than 10.
- 12 policies in our sample required that facilities provide 24-hour nursing service for custodial care, even though this was not a requirement in most of the states we visited in which the policies were for sale.
- 22 policies required that facilities keep daily medical records for each nursing home resident, even though neither Medicare nor the states we visited have this requirement.

Two complaints to state commissioners illustrate the problems that policyholders face with restrictions on eligible facilities. One policyholder learned that his insurer would not provide benefits unless he received care in a nursing home that maintained a daily medical record for each resident; he discovered that his state did not require such records and that he would have difficulty locating a nursing home in his area that did. Another policyholder complained that her insurer would not provide benefits unless she received care in a nursing home with 24-hour nursing services; the policy also required that these services be provided by a registered nurse. Yet none of the nursing homes in her area met these requirements.

Eligibility Criteria

Eligibility criteria in our sample policies were often vague, were insufficient to assess the eligibility of many individuals with physical or mental impairments, or had implications for restricting benefits in ways that were not obvious. NAIC recommends that states prohibit insurers from using certain eligibility criteria, such as prior hospitalization. NAIC does not suggest or endorse, however, alternate eligibility criteria or guidelines for applying such criteria.

Many insurers replaced the prior hospitalization criterion with one that requires "medically necessary" care. However, 6 of the 30 policies reviewed that used the medical necessity criterion for determining eligibility left the term undefined. For other policies, the definition varied. In

Inflation Protection

Inflation-related standards provide protection against the rising cost of long-term care. NAIC standards require that the daily benefit amount, such as $80 a day for nursing home care, be compounded annually at 5 percent or more. At a lower rate, policyholders are likely to find their benefits eroded over time and inadequate to cover costs. However, of the 34 policies in our sample that offered inflation protection, only 1 met the NAIC standard that benefits be increased at the rate at least of 5 percent compounded annually.

Most of the other 33 policies that offered inflation protection used a simple rate of inflation that increased benefits annually by 5 percent or less of the original benefit. Whether a policy uses this simple rate is important, especially the longer a policy is held. For example, a 65-year-old person who buys a policy that pays an $80-a-day nursing home benefit with annual benefit increases at a simple rate of inflation of 5 percent a year would at age 85 see the benefit's daily value increase to $160. In contrast, if the policy used a rate compounded annually at 5 percent, it would pay $212 daily. This $52 difference can be substantial for elderly people who would have to pay this daily difference.

Many of the same policies that used a simple rate of inflation of 5 percent also limited the inflation increases to a certain period (generally 10 to 20 years), to a percentage of the daily benefit (generally 50 to 75 percent), or to until the time a policyholder reaches a certain age. The age limits were most restrictive for elderly policyholders. For example, under two policies, inflation adjustments stop when a policyholder reaches age 70. Because the average policyholders are near this age when they purchase long-term care insurance, policies with age limits can effectively eliminate inflation protection for many policyholders.

Home Health Care

Some policies we reviewed also did not meet NAIC standards for determining eligibility for home health care. These standards were designed to eliminate provisions that NAIC deemed overly restrictive. Specifically, these provisions required a policyholder to receive nursing home care before being eligible to receive home health care and required a physician to certify that the policyholder would need hospital or nursing home care in the absence of home health care. NAIC deemed both provisions as too restrictive because they tie the need for home health care to a higher, more intensive level of care. The effect of these restrictions is to greatly reduce the likelihood that a policyholder will receive home health care benefits. Of the 37 policies that offered home health care, 10 contained such restrictive provisions. Of these, five contained the prior

groups and private and government actuaries. We considered all these views in assessing the adequacy of NAIC model standards in addressing consumer protection issues.

Our work was performed from April 1990 to February 1991 in accordance with generally accepted government auditing standards.

States Lag in Adopting NAIC Standards

States have progressed since we last reported on the issue,[3] but most states still lag in adopting key NAIC standards. The differences between NAIC and state standards may result, in part, from the time required to develop new legislation or regulations. However, many states still do not meet NAIC standards developed between 1986 and 1988. For example, 19 have not developed standards, or met those developed, prohibiting prior hospitalization requirements. Such standards state that insurers cannot require that policyholders be hospitalized before entering a nursing home. NAIC prohibited prior hospitalization as a condition for eligibility because it severely limits the number of policyholders who can receive benefits.

In addition, 23 states have not developed standards requiring insurers to guarantee policy renewal, and 19 have not adopted standards prohibiting exclusions for Alzheimer's disease. These standards are basic to ensuring that policyholders are able to maintain coverage and that policyholders with Alzheimer's disease who need long-term care are not summarily excluded from receiving benefits.

Even fewer states have passed legislation meeting the standards NAIC has established since 1988. For example, 40 states have not adopted NAIC standards for home health care benefits, inflation protection, or disclosure requirements for post-claims underwriting.[4] Appendix III summarizes the status of state enactment of key NAIC consumer protection provisions.

[3]Long-Term Care Insurance: State Regulatory Requirements Provide Inconsistent Consumer Protection (GAO/HRD-89-67, Apr. 24, 1989).

[4]Post-claims underwriting occurs when an insurer checks a policyholder's medical history only after a claim is filed. This may result in a denied claim if the insurer determines that the policyholder provided invalid medical-related information on an application.

Second, NAIC standards themselves do not sufficiently address several features of long-term care insurance that have important consequences for the consumer. For example, policy terms, definitions, and eligibility criteria are often expressed in language that is vague and inconsistent across policies. The language may also have implications that restrict benefits in ways that are not obvious. These problems make it difficult or impossible to compare policies and to judge which provisions can reduce the likelihood that a policyholder will receive benefits.

Consumers also face great financial risks. For instance, price is not a good indicator of value—premiums can vary as much as 150 percent for policies with similar benefits. Further, insurers' setting of policy prices in a new market without experience data requires periodic adjustments. As a result, consumers are vulnerable to price hikes that could make it difficult for them to retain their policies. Policyholders who allow their policies to lapse, however, almost always lose the investment component of their premiums. Finally, in the absence of certain marketing standards, consumers are limited in their options to upgrade policies and are vulnerable to abuses in the sale of long-term care insurance.

To address these issues, we believe that NAIC standards should be extended to require greater uniformity of language among policies, improve methods for determining eligibility, and provide greater protection against loss of a policyholder's coverage and financial investment. If states fail to incorporate these and existing NAIC standards into their laws and regulations, the Congress may wish to consider legislation that sets federal minimum standards for long-term care insurance.

Background

Long-term care, which refers to medical and support services provided to people who cannot function independently because of a chronic illness or condition, presents an unbearable financial strain for most people. Care provided in a nursing home, for example, can cost $30,000 or more a year. As a result, many consumers may turn to private insurance as a way to defray long-term care costs. Before 1986, few companies offered long-term care insurance, but by June 1990, 1.6 million policies had been sold by 130 or more companies.[2]

[2]S. Van Gelder and D. Johnson, "Long-Term Care Insurance: A Market Update." Health Insurance Association of America Research Bulletin (Washington, D.C., Jan. 1991), p. 2.